New Start MEDICAL

New Patient Intake

Name: _______________________________________ DOB: ___/___/___ AGE: _________ SEX: ___________
Mobile Phone #: ____________________________ Home Phone #: ________________________________
Email address: ___________________________ Street address: ____
City: __________________________ State: _______ Zip: _________ Occupation: ________________________

Primary Insurance: _________________________________ ID# ______________________________________
Secondary Insurance: _______________________________ ID# _______________________________________

Emergency contact: _______________________________ Phone #_________________ Relationship_________

Are you in good health at the present time to the best of your knowledge? Y N

Do you have any drug allergies? Y N
What: _________________ Reaction: _____________________________
What: _________________ Reaction: _____________________________

Do you have any food allergies or intolerances? Y N
What: ________________ Reaction: ______________________________

Please list current medications name, doses, and frequency:

Name:_______________________________ Dose:________________ Frequency:______________
Name:_______________________________ Dose:________________ Frequency:______________
Name:_______________________________ Dose:________________ Frequency:______________
Name:_______________________________ Dose:________________ Frequency:______________

Please list current supplement name, doses, and frequency:

Name: _______________________________ Dose: ________________ Frequency: ______________
Name: _______________________________ Dose: ________________ Frequency: ______________

Please list previous surgeries and approximate year of the procedure:
____
____

Care Team:
Primary Care Provider: ____
Cardiology: ____
Endocrinology: ____
GI: ____
Pulmonary: ____

Preferred Pharmacy Name: _________________________ Address: _______________________
City: __________________ Zip: ________ Phone #: __________________________

Women only:

Is there a chance you can be pregnant now? Y N
Have you ever been diagnosed with PCOS, polycystic ovarian syndrome? Y N
Have you ever been diagnosed with gestational diabetes? Y N

<u>Have any immediate family members ever had any of the following?</u>

Overweight/Obesity:	Y	N	Who: ____
Glaucoma:	Y	N	Who: ____
High Blood Pressure:	Y	N	Who: ____
Kidney Disease:	Y	N	Who: ____
Diabetes:	Y	N	Who: ____
Psychiatric Disorder:	Y	N	Who: ____
Heart Attack:	Y	N	Who: ____
Heart Failure:	Y	N	Who: ____
Stroke:	Y	N	Who: ____

<u>Your Past Medical History</u> (circle all that apply)

High Blood Pressure	**High Cholesterol**	**Hypothyroidism**
Diabetes Type 2	**Diabetes Type 1**	**Prediabetes**
Sleep Apnea	**Gallbladder Disease**	**Fatty Liver Disease**
Lung Disease	**Pneumonia**	**Asthma**
Kidney Disease	**Kidney Stones**	**Jaundice**
Heart Disease	**Heart Failure**	**Rheumatic Fever**
Atrial Fibrillation	**Heart Valve Disorder**	**Tuberculosis**
Bleeding Disorder	**Anemia**	**Blood Clots**
Stomach Ulcers	**Varicose Veins**	**Venous Stasis (Swelling)**
Depression	**Gout**	**Insomnia**
Eating Disorder	**Anxiety**	**Bipolar Disorder**
Osteoporosis	**Alcohol Abuse**	**Drug Abuse**
Stroke	**Acid Reflux**	**Cataracts**
Barrett’s Esophagus	**Idiopathic Intracranial Hypertension**	**Migraine Headaches**
Cancer		

Nutrition Evaluation

Present Weight: __________ Ht: ________ Goal Weight: _________ Last time at goal weight ______________

In what time frame would you like to be at your desired weight? Please circle:

3 months 6 months 12 months 18 months ASAP

Weight one year ago: ______________

What is the main reason for your decision to lose weight?

____

____

When did you begin gaining excess weight? (Give reasons, if known);

____

What has been your maximum lifetime weight and when?

____

Please list previous diets you have followed.

____

____

____

What has been the most successful approach for you? ____

Is your spouses, fiancé, or partner supportive of your efforts to lose weight? Y N

How often do you eat out? ____

What restaurants do you frequent? ____

How many times a week do you eat fast foods? ____

What is your favorite fast food restaurant? ____

Who plans and cooks meals in your household? ____

Do you enjoy prepping and cooking meals? Y N

Do you have any food dislikes? Please list: ____

List foods you crave: ____

Do you have trouble drinking water? Y N

How much water do you typically drink a day? ____

How many cups of coffee/tea do you drink in a day? ___________ Do you add anything to it? ______________

How many regular soft drinks do you drink a day? ____________ Diet Soft Drinks? ______________________

How many drinks of alcohol do you have per week? ____

What type of alcohol do you drink? ____

<u>Tobacco use (please circle one):</u>

Never a smoker **Former Smoker** **Light cigarette smoker (1-9 cigs/day)**

Moderate cig smoker (10-19 cigs/day) **Heavy cig smoker (20-39 cigs/day)** **Snuff user**

Very Heavy cig smoker (40+ cigs/day) **Cigar Smoker** **Pipe Smoker** **Chews Tobacco**

Electronic cigarette user

Do you use sugar substitutes? If so, what kind? ____

Do you awaken hungry during the night? **Y** **N**

What do you eat when you wake up at night? ____

Have you ever found evidence of night time eating without your knowledge? **Y** **N**

What are your worst food habits? ____

Do you binge eat? If so, how often? ____

Have you ever induced vomiting or taken laxatives or diuretics for weight loss? **Y** **N**

Have you ever been diagnosed with Bulimia or Anorexia Nervosa? **Y** **N**

When you are under a stressful situation, do you tend to eat more? If so, please describe:
____
____

Do you think you are currently undergoing a stressful situation or emotional upset? **Y** **N**

Do you ever skip meals? Y **N** **If yes, which meal do you skip and why?** ______________________

Describe your usual energy level: ____

How many hours of sleep do you get a night: ____

Do you have problems falling asleep: **Y** **N**

Do you have problems staying asleep: **Y** **N**

What is you activity level:

_______ Inactive – No regular physical activity and has a sit down job
_______ Lightly Active – Some physical activity but no regular exercise
_______ Moderately Active – Exercise 1-2 times per week
_______ Heavily Active – Exercise 3-4 times per week
_______ Vigorously Active – Participation in physical exercises 5 times per week

What type of exercise do you enjoy: ____